Informed Prostate Cancer Support Group Inc.
"A 501 C 3 CORPORATION ID # 54-2141691"

DECEMBER 2017 NEWSLETTER

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We Meet Every Third Saturday (except December)

Thursday, December 28, 2017

Volume 10 Issue 12

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Next Meeting
January 20, 2018
10:00AM to Noon

Meeting at

Sanford-Burnham-Prebys Auditorium

10905 Road to the Cure, San Diego CA 92121

SEE MAP ON THE LAST PAGE

What We Are About

Our Group offers the complete spectrum of information on prevention and treatment. We provide a forum where you can get all your questions answered in one place by men that have lived through the experience. Prostate cancer is very personal. Our goal is to make you more aware of your options before you begin a treatment that has serious side effects that were not properly explained. Impotence, incontinence, and a high rate of recurrence are very common side effects and may be for life. Men who are newly diagnosed with PCa are often overwhelmed by the frightening magnitude of their condition. Networking with our members will help identify what options are best suited for your life style.

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Editor: Stephen L Pendergast

PROSTATE CANCER IT'S ONLY 2 WORDS NOT A SENTENCE

Summary of Last Meeting by Bill Lewis

Prostate Cancer – Annual Update: New Research Findings in 2017

Richard Lam, MD; Prostate Oncology Specialists in Marina del Rey

Prostate cancer is one of the most common types of cancer in the U.S. and the 2nd leading

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Video DVD's

DVD's of our meetings are available in our library for $10ea. Refer to the index available in the library. They can also be purchased through our website: http://ipcsg.org Click on the 'Purchase DVDs" button.

The DVD of each meeting is available by the next meeting date.

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cause of cancer death in men. Approximately 1 in 7 men will be diagnosed with PC during his lifetime. In 2016, the estimated number of new cases was 180,890. The estimated number of deaths was 26,120. There were 2,850,139 men living with prostate cancer in 2013.

1. Low Risk Prostate Cancer – defined by PSA <10; Digital rectal exam (DRE) = T1c (no nodules) or T2a (small nodule); Gleason Score = 3+3 or "select" 3+4; <25% of 12 biopsy cores involved; favorable genetic profile; small or no lesions seen on MRI or Ultrasound. Management options for Low Risk Disease include Active Surveillance (increasingly used) and various forms of Local Therapy. FDA-approved therapies include External Beam Radiation Therapy (photons or protons), Brachytherapy (Radioactive Seeds implanted temporarily or permanently), Surgery (Radical Prostatectomy, often robot-assisted), Cryosurgery (Freezing), or HIFU (High Intensity Focused Ultrasound; approved in 2015).

The 10-year follow-up results of the ProtecT Trial show overall survival was essentially the same for the three test groups: Active surveillance, Surgery or Radiation. About 10% of the men died during this period, and they were about 8 times as likely to have died of something other than their prostate cancer. Only about 1% of the men died from prostate cancer during the 10 years. However, the men on Active Surveillance did show progression of their disease, including metastases, more than twice as often as those in the other arms of the study. But until such progression, they avoided the significant negative side effects experienced by those who underwent surgery or radiation treatment.

In the PIVOT trial, which is approaching 20 years of follow-up, 731 men were randomized between Surgery and the forerunner of Active Surveillance, which was called Watchful Waiting, and involved less intensive monitoring of the patient. At the start of the study, the median age was 67, and the PSA was 7.8 (both higher than in the ProtecT Trial). All-cause mortality was statistically the same in the two groups, at about 65%. However, there was an apparent modest benefit of Surgery for men who were over 65, had a PSA >10 and/or who had intermediate-risk disease.

2. Intermediate Risk, defined as Gleason score = 7; no or small nodule found by DRE; PSA between 10 and 20; >50% of cores involved; organ confined cancer (no extracapsular extension nor seminal vesicle involvement, as determined by imaging); and an "intermediate" genetic panel. Management options do not include Active Surveillance, but do include Local Therapies listed above, plus one type of Systemic Therapy, namely, ADT (Androgen Deprivation Therapy; also called Hormone Therapy). Arguments in favor of Local Therapy include fear of having cancer in the body, the "dangerous" nature of prostate cancer, the possibility of "closure," and the avoidance of hormone therapy (trading off the side effects of Local Therapy vs those for ADT). The side effects of Lupron, the most commonly used ADT drug, include hot flashes, fatigue, gynecomastia (breast growth and pain), osteoporosis, muscle wasting, erectile dysfunction, depression, weight gain, insulin resistance, high cholesterol, anemia, and memory impairment. No joke! On the other hand, Local Therapy often causes impotence and incontinence. Radiation treatment may cause proctitis (burning of the rectum, and possible fecal incontinence.

There is increasing use of "hypofractionated" radiation treatment, in which the same total radiation dose is given in 20-28 or even as few as 5 visits instead of the standard 39-44 visits. It's more convenient and less expensive, but it's not yet clear whether it is more or less effective, and whether it is equally safe. In the PROFIT Trial (Prostate Fractionated Irradiation Trial; note the humorous acronym), 1206 men were randomized to 4 weeks vs 8 weeks of radiation, being given the same overall dose. After 6 years, all results were practically equivalent, with the exception that the 4-week treatment gave more acute bowel effects and the conventional treatment gave more "later" bowel effects. With the availability of SpaceOAR gel to protect the rectum, these last differences may become irrelevant.

As opposed to "Local" (but still whole-gland) therapy, there are various types of "Focal Therapy," tar-

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geting just a portion of the prostate, which include Focal versions of Cryosurgery, HIFU, Seeds, and also Laser and Botox. A recent small study from UCLA involved 10 men with intermediate risk disease who were treated with Focal Laser Therapy in a single outpatient session, guided by MRI and ultrasound, with local nerve block and mild sedation. A laser-tipped probe delivers heat, and several other probes monitor the resulting temperature in critical zones of the prostate. The results included no change in urinary or sexual function, moderate pain during the procedure, and mild bleeding. After 6 months, three men had no cancer detected in a repeat biopsy, and several others showed less cancer than before.

3. High Risk Prostate Cancer, defined as Gleason score = 8 to 10; large nodule by DRE; PSA greater than 20; >50% of biopsy cores show cancer; and imaging shows extracapsular extension or seminal vesicle involvement. Treatment options include Surgery with or without EBRT (radiation); EBRT with or without Seeds; or Systemic Therapy. Besides ADT, Systemic Therapy options now include either Chemotherapy or Abiratirone (Zytiga) added to the usual ADT drug(s).

The ASCENDE-RT Trial of 398 men showed that EBRT plus Seeds is better than EBRT alone for high-risk prostate cancer. After 3 years, both groups were 94% free of "relapse" (resurging growth of cancer), but after 9 years, only 63% of the EBRT-only men were still free of relapse, but 83% of the EBRT + Seeds group were free of relapse.

The STAMPEDE Trial with 1917 men in the United Kingdom is showing that giving Abiraterone (Zytiga) is useful for men with "castrate sensitive" prostate cancer, whereas in the past it was only given to men with "castrate resistant" (no longer sensitive to hormone deprivation) disease. These were/are seriously ill men: The median PSA was 53. About half had "distant" metastases, and 20% had nearby lymph nodes infected. Radiation was given to 41% of the men. After 3 years of follow-up so far, overall survival was modestly different: 83% vs. 76%, but freedom from relapse was 75% vs. 45%, and significant bone problem occurrences (e.g., pain or breaks) were cut nearly in half.

4. Relapsed Disease: Relapse after surgery is manifested by a rising PSA, and the traditional curative treatment is radiation to the prostate "bed." The success rate varies from 20-70%, depending on Gleason score, margin status, and PSA (including its nadir and subsequent doubling time). There has been no prospective survival benefit demonstrated for adding hormone therapy until this year. A study of 760 men, of whom half were given bicalutamide (Casodex) at 150 mg daily for 24 months, with 12 years of follow-up, showed significantly less relapse, and only 6% dying from prostate cancer after 12 years, vs. 13% among the control group. Dr. Lam noted that one of the most significant side effects of bicalutamide is breast growth.

5. Metastatic disease: Not treated by local therapy, but instead by Systemic Therapies, such as ADT; Chemotherapy (usually Docetaxel [Taxotere], which may eventually be followed by Cabazitaxel [Jevtana]); Abiraterone (Zytiga); Enzalutamide (Xtandi); Provenge; or Radiopharmaceuticals such as Xofigo (which carries Radium into bone metastases). Emerging treatments include PSMA agents containing Lutetium or other elements; Immunotherapy (such as with PD-1 inhibitors); and possibly, High Dose Testosterone.

The CHAARTED and STAMPEDE trials published in 2015 and 2016 showed that early Chemotherapy (while the disease is still hormone-sensitive) extends lives.

More recently, a report from another arm of the STAMPEDE trial in the UK, involving 1900 men, in which half received ADT alone, and half also received Abiraterone (but note that 41% of the whole group also received radiation), shows very promising 3-year results. The three-year "failure-free survival" (i.e., no discernable advancing of the disease) was 75% for the drug combination, vs. 45% for ADT alone.

In the LATITUDE trial (Europe, Asia, Canada and Latin America), about 1200 men with metastatic

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prostate cancer (and who had at least two of: Gleason >7, >2 visceral metastases, or >2 skeletal lesions) were given Abiraterone + ADT or ADT alone, as in the UK study. Median follow-up time so far is 30 months. The median time to PSA progression was 33 months for the drug combination, versus only 7.4 months for ADT only. But the three-year overall (all-causes) survival was still only 66%; which at least was better than the 49% in the control group. Side effects are modest with co-administration of a low dose of Prednisone.

PD-1 inhibitors such as Keytruda and Opdivo are drugs that bind to a protein on the surface of prostate cancer cells that is called PD-L1. In the absence of such drugs, the PD-L1 protein can bind to a receptor on T-cells that is called PD-1 (programmed death receptor #1). When this binding occurs, it inhibits the normal action of the T-cell to kill the cancer cell, and the cancer survives. When the inhibitor-drug is present, the PD-L1 protein is blocked, and the T-cell carries out its "normal" killing of the cancer cell.

Keytruda is such a PD-1 inhibitor. The KEYNOTE-028 study found significant benefits to about half of a group of 23 men with heavily-pretreated castrate-resistant prostate cancer. At Prostate Oncology Specialists, Dr. Lam and associates have treated 31 men (27 of them "castrate-resistant") with baseline PSA = 8.1. Seventeen have had a partial PSA response, or now have stable disease. The other 14 have had their disease continue to "progress" (worsen). Follow-up continues.

At this year's ASCO (Amer. Soc. of Clinical Oncology) conference, a small NCI-NIH study was reported, in which ten men (median PSA: 86) were treated with Darvulumab (Imfinzi) + Olaparib (a PARP inhibitor, which inhibits an enzyme called poly ADP ribose polymerase, and appears useful in treating various cancers). Among the first seven treated, five men had their PSA drop by more than 50%, including drops of 99, 94 and 79 percent.

Other promising Immunotherapy trials are in progress, using various combinations of drugs – which Dr. Lam believes will be necessary for effectiveness against prostate cancer. Stay tuned!

Treatment with Xofigo (Alpharadin; Radium 223 attached to a carrier molecule that binds to prostate cancer metastases in the bones, and emits short-range, energetic alpha particles that kill the cancer while mainly sparing other cells) involves 6 monthly injections, and results in improved overall survival and decreased bone pain. In 2015, it was shown to be safe when used with Xtandi or Zytiga.

Lutetium-177 labeled PSMA (prostate-specific membrane antigen) therapy has shown dramatic results against both bone and soft-tissue metastases, and is available in Australia and Germany. A trial at UCLA has just started. It may cause severe anemia. Other agents are under development.

There are emerging data on the possible value of Bipolar Androgen Therapy. In the RESTORE trial,

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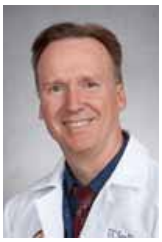
FUTURE MEETINGS

December 2017 - No Meeting



- January 20 2018 - Dr. Arno J. Mundt, MD & Dr. John P. Einck, MD of the UCSD Department of Radiation Medicine will give an update on the current state of radiotherapy approaches including intensity-modulated radiotherapy (IMRT), image-guided radiotherapy (IGRT), stereotactic radiosurgery and brachytherapy technique.

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reported in December 2016, 30 men with metastatic "castrate-resistant," Xtandi-resistant disease were treated with 400 mg Testosterone injections monthly, while staying on ADT. Nine had >50% PSA reduction. The median time to progression was 8.6 months. There were some side effects, including a heart attack, a pulmonary embolism, a bladder blockage, and two men who had pain flare-ups.

Developments expected in 2018 and beyond include studies of combinations of immunotherapies, usefulness of immunotherapy against oligometastases, cancer genetics, next generation radionucleotide therapies (lutetium or actinium), and more data on Olaparib (PARP inhibition), focal therapies and shorter-course irradiation.

A new book by Mark Scholz, a partner at Prostate Oncology Specialists, is titled The Key to Prostate Cancer, and includes 30 experts who explain 15 stages of prostate cancer.

In summary,

Low risk patients: Active surveillance will become the standard of care. Focal laser therapy is interesting.

Intermediate risk patients: Shorter course radiation (hypofractionated) is equivalent to the standard 8 wk duration.

High risk patients: Seeds + radiation might be the most effective treatment. Early abiraterone is an option.

Relapsed disease: Adding bicalutamide improves salvage radiation effectiveness and overall survivial.

Metastatic disease: Early abiraterone and/or early Taxotere is beneficial. High dose testosterone needs more study.

Immunotherapy and radiopharmaceuticals: These are the next frontier.

Questions:

Use of testosterone to correct a low testosterone level, for men with prostate cancer? Dr. Lam thinks it can be a reasonable risk, since prostate cancer acts more like a chronic disease than most cancers, and even if the testosterone causes a relapse, this can be usually recovered from if the supplementation is stopped.

Usual sequence if both brachytherapy and radiation are given? Usually, the radiation comes first.

What is the role of DHT (dihydrotestosterone)? It feeds prostate cancer more than testosterone. So blocking its formation using Finasteride (Proscar) or Dutasteride (Avodart) slows cancer growth, and may be a way to postpone going on Lupron or Firmagon (and thus avoiding their side effects!), or to extend active surveillance or reduce the frequency of biopsies when on active surveillance. [George Johnson noted that he was able to use Casodex + Avodart for ten years before he had to go on Firmagon.]

Data for HIFU (high intensity focused ultrasound)? It is normally used to treat the whole prostate, and is 70-80% successful. There is limited data on its use for focal treatment, but that appears to give 50-60% success. It's less precise than the laser, so more risk of side effects. In a few cases, there were fistulas causing crossover of feces and urine, so Dr. Lam is not enthusiastic about the technique.

How do people die from prostate cancer? It's usually related to the cancer in the bones. The body doesn't make enough red blood cells, platelets and white blood cells to keep surviving. The patient becomes increasingly weak. It may also attack the kidneys or the liver. It appears to Dr. Lam like "accelerated aging."

What does Finasteride do? It is normally used to shrink the prostate, and that results in a lower

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PSA, usually by half. Be aware of this, in looking at PSA rise before and after going on Finasteride. Men who relapse after prostatectomy, also can get a reduction in PSA on Finasteride, which is evidence that the drug has a direct inhibitory action against prostate cancer (i.e., not just in normal prostate cells).

What does Zytiga do? Lupron tells the testicles to stop making testosterone. But the adrenals also produce a little, and this can promote prostate cancer growth. Zytiga shuts down the non-testicular production of testosterone, including that which prostate cancer cells may begin making themselves, and probably also further shuts down testicular production. A pill, taken on an empty stomach. Side effects: leg swelling, hypertension, electrolyte or liver effects, increase in hot flashes. It may be available as a generic in 2-3 years.

Length of time on Zytiga? In the study, men stayed on it as long as it was working. For a number of men it was still working (to keep the cancer in check, and the PSA low) even after three years. We don't know what would happen if the Zytiga were stopped. But long-term remission is unlikely in metastatic prostate cancer. In a patient with oligometastatic disease, there is some data suggesting that if there were one or two spots, and they could be irradiated, along with Chemo or Zytiga treatment, there might be durable remission.

"Nanoknife" value? Stimulation of immune system by fragments of dying cancer cells? There isn't enough data on Nanoknife for Dr. Lam to offer an opinion yet. [Note: see Sept 2016 talk at IPCSG or write to lewis.bill@gmail.com for a discussion of this technique, which is also called irreversible electrophoresis, and is now offered in San Diego.] He expects that there will be some benefit to the immune system, from cell fragments generated by various treatments. Some of his patients with oligomets are being treated with this potential benefit in mind [for example, by irradiating a metastasis, and giving Keytruda to stimulate the immune response to the dying cells].

Prostvac approval status? It's a vaccine that appeared promising in Phase 2 trials, but failed in the Phase 3 trial, which was just reported. [A member was in the trial, and felt it worked for him.]

Enzalutamide (Xtandi) vs. Abiraterone (Zytiga). Both can be used on castrate-resistant patients. Data on Xtandi for hormone sensitive patients is expected to be published next year. Until then, Zytiga will be used.

Prednisone use with Zytiga? Dr. Lam thinks it's excessively feared. He uses only 5-10 mg doses.

Low vs. high dose brachytherapy – do results compare? Yes.

Can we adjust the dose of Casodex? The data going back 20 years is all on 150 mg dosing. [George Johnson varied his dose, and settled on 50 mg for most of his 10 years.]

Cost of Zytiga – what are the options? Medicare Plan D drug plan is very helpful, but can leave you with $10-20,000 in copays. [Note: mine is about $8500] It is also possible to get financial assistance in the form of grants [I recently got a $6500 grant to help with the copays. Also, I believe Gene Van Vleet had a very good program when on Zytiga]. In England, they have found that if you take Zytiga with food, instead of on an empty stomach as normally recommended, more of the drug gets absorbed, so a half-dose is effective! [Comments by Steve Pendergast: Because of the so-called "donut hole" in Medicare drug coverage, it will cost about $3500 at first in 2018, and then about $400-450 per month for the rest of the year. George Johnson paid $5000 the first month, and then $1000 per month for the rest of the year, so it all depends on the insurance you have.] For those who don't have insurance, Johnson and Johnson will accept aid applications, and the patient may get the drug for free.

Cost for Taxotere? It consists of 6 one-hour infusions at the doctor's office. Then you are done, except for continuing injections of Lupron or Firmagon. And the treatment is covered by Medicare. So it's very much less expensive than a year or several years of Zytiga. You just have to compare the costs

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and side effects.

What to do in combination with salvage radiation after prostatectomy? As shown in the talk, it appears that 2 years of Bicalutamide (Casodex), beginning at the start of radiation, is helpful.

What about genetic testing? Dr. Lam often does tests on the first biopsy samples, to understand more about the particular type of cancer the patient has. He also does tests on relapse of metastatic disease. Certain genetic patterns can open up the possiblility of treatments that would not otherwise be considered. For instance, Olaparib (Lynparza) is normally used for ovarian cancer, but may be helpful against prostate cancer if the BRCA gene mutation is present in the prostate tumors.

For recurrent prostate cancer, would Lupron or Lupron + Zytiga be appropriate? If no metastases, Dr. Lam would not add Zytiga.

What about Testosterone, and atrial fibrillation? Different studies show a risk from Lupron, or not. The data aren't consistent. But Dr. Lam thinks there is an effect, because weight goes up, cholesterol goes up, and there may be diabetes. Your doctor needs to fine tune your meds, and you should exercise and eat well. Metformin and cholesterol pills may also mitigate the risk. Note that there is also a very small risk for heart rhythm issues, like about 1% vs. 0.5% of men not taking the drug. [George Johnson noted that his first 3-month Lupron shot gave him atrial fibrillation and other heart problems. He got off that, and was able to use Casodex and Avodart for ten years, but now needs to use Firmagon -- which reportedly has only half of the heart risk as Lupron.]

George also added a comment about active surveillance: although mortality has been reported to be a little higher than for groups of men who underwent surgery or radiation right away, his close inspection of the data suggests that three men in the active surveillance group should have been disqualified due to high PSA and Gleason score. So he feels active surveillance is a very appropriate option for certain men, and notes that it doesn't have the negative side effects of surgery or radiation treatments.

Articles of Interest

Blood Test Performs as Well as Tissue Biopsy in Characterizing Prostate Cancer, Study Finds [*no more poke and hope? ed.*]

prostatecancernewstoday.com/2017/12/22/blood-biopsy-breakthrough-analyzing-prostate-cancer/

Magdalena Kegel December 22, 2017

A blood test may one day replace tumor tissue sampling for patients with prostate cancer, as research shows that nearly 90 percent of a tumor's genetic features can be detected in the blood.

Such blood biopsies may make it easier for physicians to choose treatment, and monitor a patient for disease progression and treatment response, said researchers behind a recent study published in the journal Nature Communications.

"Our ultimate hope is to use blood biopsies to exhaustively search for and characterize even the smallest remnants of tumors," Viktor Adalsteinsson, PhD, co-first study author and leader of the Blood Biopsy Team at the Broad Institute of MIT and Harvard University, said in a press release.

"And, as tumors evolve in more advanced stages of cancer, developing resistance or becoming metastatic, we might access timepoints that could be pivotal in deciding which therapies are right for that patient."

While the idea to track cancer by measuring its DNA in the blood is not new, the study, "Scalable whole-exome sequencing of cell-free DNA reveals high concordance with metastatic tumors," improves many of the tools

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used to make the method more robust.

The key to tracking tumor properties in blood is the presence of DNA in the bloodstream. When cells die, some of their DNA leaks into the blood. And since tumor DNA differs from that of healthy cells, it potentially can be analyzed.

Up to now, however, the procedure has been hampered by several issues. For instance, a so-called whole-exome analysis requires at least 10 percent tumor DNA in a blood sample. But the amount of tumor DNA can vary widely, researchers said.

Today, it is common to identify tumor DNA by analyzing specific cancer-related genes. But not all tumors carry these specific mutations, making detection of cancer DNA suboptimal. Instead, the team developed a new method, called ichorCNA.

Instead of looking at specific genes, this tool analyzes mutational patterns that are nearly universal in cancer.

Using ichorCNA on 1,439 blood samples collected from 520 patients with metastatic breast or prostate cancer, the team found that between 33 to 49 percent of patients had at least 10 percent cancer DNA in their blood.

"Using cell-free DNA to track cancer is not a new idea, but we're developing the tools to understand how we can better qualify materials for those types of analyses," said J. Christopher Love, PhD, one of the senior study authors, and an associate professor of chemical engineering at MIT.

"We've established quality metrics to make sure that this technology is cost-effective and scalable for thousands of patients and samples a year," added Love, who also is a member of the Koch Institute for Integrative Cancer Research at MIT.

In the next step of the study, the team compared the genetic analysis of tumor DNA from blood samples to those performed in tumor tissue. They found that the analyses were well-matched across a range of genetic features.

Importantly, the blood test method is adapted for use in thousands of patients, which is key if it is to be introduced in clinical settings.

"Our study has demonstrated that we can get a cancer whole exome reliably, from blood; that it reflects the matched tumor biopsy; and that it can be done for a significant fraction of patients with metastatic cancer," said Adalsteinsson.

"This validation suggests that we can use blood biopsies for large-scale genomic characterization of disease in patients with metastatic cancer."

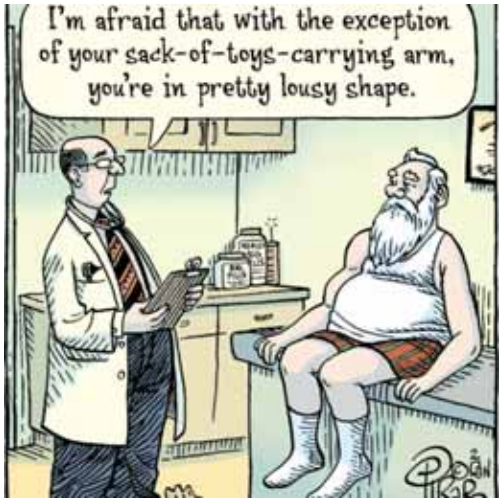
Gad Getz, PhD, another senior author of the study, underscored that their findings open the door for research that could not have been done earlier.

"The technology will allow us to track the dynamics of cancer and understand the evolution of drug resistance, or the development of the metastatic state, in a way that isn't possible through surgical biopsies," said Getz, who is a director of the Cancer Genome Computational Analysis group at Broad. He also is associate professor of Pathology and director of Bioinformatics at the Massachusetts General Hospital Cancer Center.

"With this work, we now have a framework for the precise measurement and quality control of tumor DNA in the plasma, enabling the genomic analysis of blood biopsies with high technical accuracy," added Matthew Meyerson, MD, PhD, the third senior study author who is an institute member at Broad and professor of pathology at Dana-Farber Cancer Institute and Harvard Medical School.

On The Lighter Side

"That's too bad. Looks like you've got a nut allergy."



"Nonsmoker, heathy diet, regular exercise. You put up a good little fight."

NETWORKING

The original and most valuable activity of the INFORMED PROSTATE CANCER SUPPORT GROUP is "networking". We share our experiences and information about prevention and treatment. We offer our support to men recently diagnosed as well as survivors at any stage. Networking with others for the good of all. Many aspects of prostate cancer are complex and confusing. But by sharing our knowledge and experiences we learn the best means of prevention as well as the latest treatments for survival of this disease. So bring your concerns and join us.

Please help us in our outreach efforts. Our speakers bureau consisting of Lyle LaRosh, Gene Van Vleet and George Johnson are available to speak to organizations of which you might be a member. Contact Gene 619-890-8447 or gene@ipcsg.org to coordinate.

Member and Director, John Tassi is the webmaster of our website and welcomes any suggestions to make our website simple and easy to navigate. Check out the Personal Experiences page and send us your story. Go to: http://ipcsg.org

Our brochure provides the group philosophy and explains our goals. Copies may be obtained at our meetings. Please pass them along to friends and contacts.

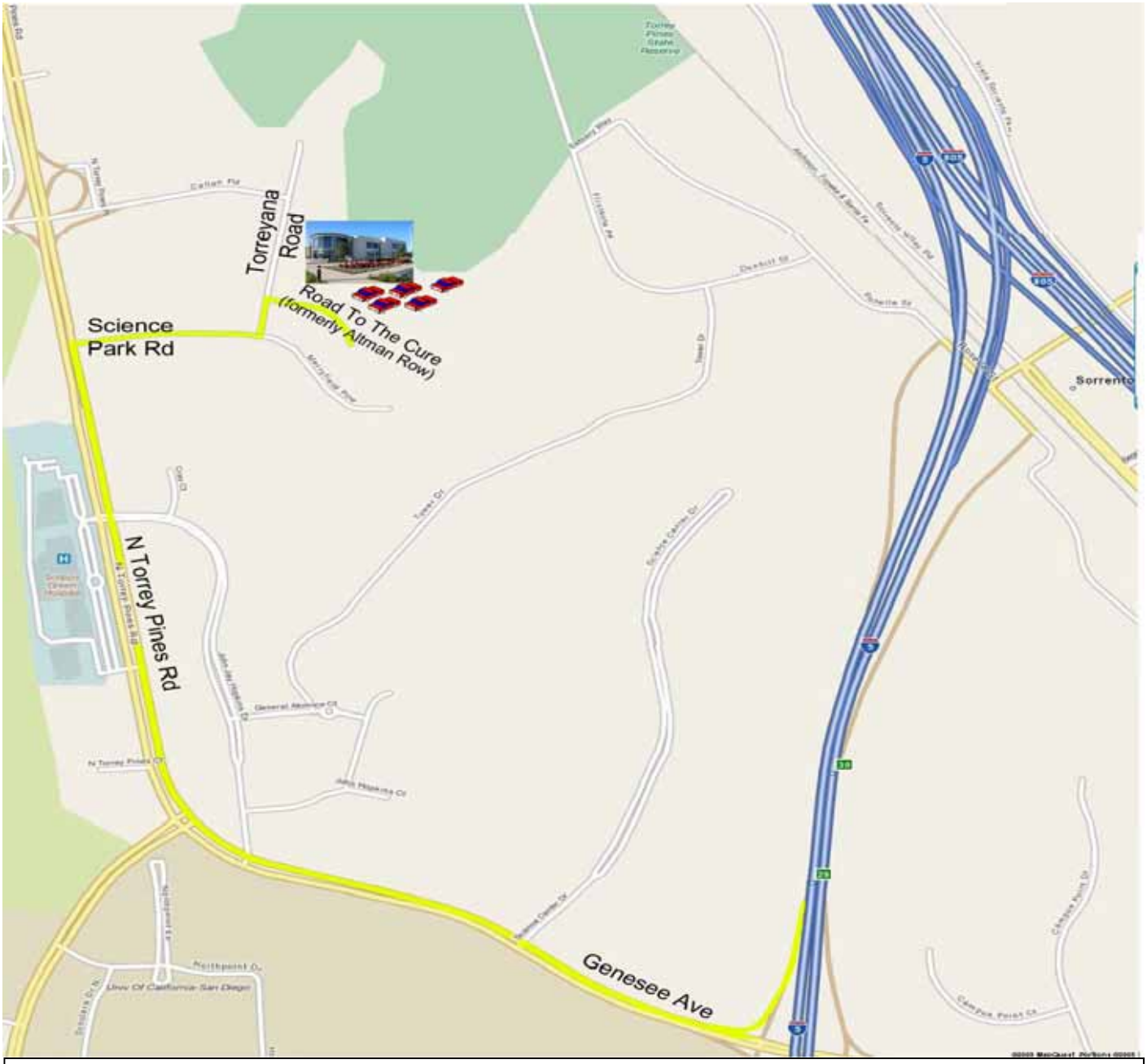
Ads about our Group are in the Union Tribune 2 times prior to a meeting. Watch for them.

FINANCES

We want to thank those of you who have made special donations to IPCSG. Remember that your gifts are tax deductible because we are a 501(c)(3) non-profit organization.

We again are reminding our members and friends to consider giving a large financial contribution to the IPCSG. This can include estate giving as well as giving in memory of a loved one. You can also have a distribution from your IRA made to our account. We need your support. We will, in turn, make contributions from our group to Prostate Cancer researchers and other groups as appropriate for a non-profit organization. Our group ID number is 54-2141691. Corporate donors are welcome!

If you have the internet you can contribute easily by going to our website, http://ipcsg.org and clicking on "Donate" Follow the instructions on that page. OR just mail a check to: IPCSG, P. O. Box 4201042, San Diego CA 92142



Directions to Sanford-Burnham-Prebys Auditorium
10905 Road to the Cure, San Diego, CA 92121

Take I-5 (north or south) to the Genesee exit (west).
Follow Genesee up the hill, staying right.
Genesee rounds right onto North Torrey Pines Road.
Do not turn into the Sanford-Burnham-Prebys Medical Discovery Institute or Fishman Auditorium
Turn right on Science Park Road. Watch for our sign here.
Turn Left on Torreyana Road. Watch for our sign here.
Turn Right on Road to the Cure (formerly Altman Row). Watch for our sign here.